Baltimore City Health Department
Ryan White CARE Act, Title I
Quality Improvement Program (QIP)

SERVICE CATEGORY:
MENTAL HEALTH SERVICES: CHILDREN AND ADOLESCENTS
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Introduction

The Baltimore City Health Department (BCHD) Title I Quality Improvement Program (QIP) began in FY 2001, the purpose of which is to ensure that people living with HIV/AIDS (PLWH/A) in the Greater Baltimore Eligible Metropolitan Area (EMA) have access to quality care and services consistent with the Ryan White CARE Act. The FY 2001 QIP initiative focused on adult/adolescent primary care and case management services, while FY 2002 focused on medically related care and care coordination. The following service categories were reviewed during FY 2002:

- Substance abuse treatment services
- Mental health services: adults
- Mental health services: children and adolescents
- Case management adherence
- Client advocacy
- Co-morbidity services

To assess the degree to which the Operational and Performance Standards for Mental Health Services to Children and Adolescents (Standards of Care) as established by the Greater Baltimore HIV Health Services Planning Council (Planning Council) were adhered to across the EMA, baseline data was gathered and analyzed from all Title I vendors in the EMA funded to provide the services listed above. Information presented in this report focuses exclusively on Mental Health Services to Children and Adolescents.

Section 1. Methodology

Process

The one to two day QIP reviews were conducted at 100% of the two agencies providing Mental Health Services to Children and Adolescents. Data was collected through three avenues: 1) consumer surveys; 2) agency surveys; and 3) client chart abstraction.

Consumer Survey: The Consumer Survey was designed to be completed by the clients. As needed, the Consumer Interviewer completed the tool while posing the questions to the client. The tool focused on three primary areas: a) general information about the consumer; b) services received; and c) level of involvement with the agency. The questions emphasized the type of services provided and client's knowledge about their care rather than on their satisfaction with services. No consumer surveys were completed by recipients of these mental health services or by their parent/guardian. Information related to consumer surveys is summarized in a separate report.

Agency Survey: Agency surveys were completed by 100% of the vendors providing mental health services for children and adolescents. The tool is a self-report of how well the agency complies with the EMA's Standards of Care. No additional verification of information was undertaken. The contact person for the agency was responsible for completing the agency tool. Information related to the agency survey is presented in Section 4. (See Appendix B for a copy of the agency survey.)

Client Chart Abstraction: The chart abstraction tool was designed to assess the vendors' adherence to the EMA's Standards of Care. The tool, which was reviewed by BCHD and the Planning Council, was developed by a content expert with demonstrated expertise in the area of mental health services. The tool contained items specifically relating to the Standards of Care, client demographics and descriptive items relating to service provision. (See Appendix A for a copy of the client chart abstraction tool.)

Time Frame

The review period focused on services provided in FY 2001 (March 1, 2001 to February 28, 2002) for Title I clients. Based on the number of clients reported receiving Title I funded services during FY 2001, vendors were instructed to randomly select a specific number of patient records who received services in the defined time frame. Recommendations for obtaining a random sample were provided. In addition, vendors were instructed to include approximately ten records that represent services initiated in FY 2001 and three to five closed records. From the vendor-selected records, the QIP reviewers selected a specified, smaller number of records to review for adherence to the Standards. For each client record reviewed, one chart abstraction instrument was completed.

The individuals conducting the QIP reviews had expertise in the service category being reviewed. Reviewers were trained in the QIP process, received written instructions for completion of the client chart abstraction instrument, participated in an orientation conference call, and were provided additional guidance as needed during the QIP review process. All completed client chart instruments were reviewed for completeness and consistency and responses were entered into a customized database for subsequent analysis.

Sample

A total of 180 clients were reported to have received services during FY 2001. A total of 42 Mental Health Services to Children and Adolescents client records were reviewed at the two agencies, representing 23% of all reported Title I clients. The number of records reviewed per site ranged from 16 to 26, with an average of 21 records reviewed per site (Table 1). The proportion of agency clients reviewed ranged from 18% to 43% of all reported Title I clients (Table 2).

Table 1. Mental Health Services to Children and Adolescents agencies reviewed, dates of review and number of Mental Health Services to Children and Adolescents client records reviewed

Agency Name	Dates of review	Number of records reviewed during QIP	% of QIP total
Johns Hopkins University/Department of Pediatrics	10/24/2002	16	38%
University of Maryland/PACE Clinic	10/21 - 22/2002	26	62%
Total		**42**	**100%**[1]

Table 2. Number of Mental Health Services to Children and Adolescents clients and proportion of Mental Health Services to Children and Adolescents client records reviewed

Agency Name	Reported # of Title I clients	% of EMA total	% of agency's clients reviewed by QIP
Johns Hopkins University/Department of Pediatrics	37	21%	43%
University of Maryland/PACE Clinic	143	79%	18%
Total	**180**	**100%**	**23%**

[1] Note on all tables: Due to rounding, the total may not be equal to one hundred percent.

Section 2. Client Demographics

Gender and age

In the sample of 42 clients, 60% of the clients were male (Table 3). The majority (52.4%) were 13–19 years of age, with only one client being 1-3 years old. The mean age was 12.8 years, with the youngest client being 2.8 years and oldest, 17.6 years (Table 4).

Table 3. Gender distribution

Gender	n=42
Female	17 (40%)
Male	25 (60%)

Table 4. Age distribution

Age	n=42
0 – 12 months	0 (0%)
1 – 2 years	1 (2.4%)
3 – 12 years	15 (35.7%)
13 – 19 years	22 (52.4%)
Not documented	4 (9.5%)
Mean age	12.8 years
Min	2.8 years
Max	17.6 years

Race/ethnicity

Of the reviewed client records, more than three-quarters (79%) were African-American. Race/ethnicity was not documented in 12% of the charts reviewed (Table 5).

Table 5. Race/ethnicity distribution

Race/Ethnicity	n=42
African-American	33 (79%)
Hispanic	1 (2%)
White	2 (5%)
Not documented	5 (12%)

Transmission risk

Perinatal transmission was the most frequently documented risk factor (55%), but the transmission risk factor was not documented in over one-third (36%) of the reviewed charts (Table 6).

Table 6. Risk factor distribution

Risk Factor	n=42
Perinatal transmission	23 (55%)
Heterosexual	2 (5%)
MSM	1 (2%)
Undetermined/Unknown	1 (2%)
Not documented	15 (36%)

Disease status, biological indicators and treatment status

Slightly more than one-half (52.4%) of the clients were documented as having HIV infection, not an AIDS diagnosis. One client died during the review period. It should be noted that disease status was not documented in almost one-quarter (23.8%) of the reviewed charts.

Of the clients whose treatment status was documented, almost all clients (88.8%) were on HAART therapy. Treatment status was not documented for 36% of the clients.

CD4 and viral load values were not documented in nearly 60% of the reviewed charts. Age and CD4 values were documented for 38% of the patients (Table 7). While the Client Chart Abstraction tool was designed to capture two CD4 and viral load values in order to be able to analyze changes in these biological markers during the review period, few of the reviewed charts contained these multiple values, so this analysis could not be conducted.

Table 7. Summary of treatment status, biological indicators

Disease Status	**n=42**
CDC-Defined AIDS	9 (21.4%)
HIV-infection	22 (52.4%)
Deceased	1 (2.4%)
Not documented	10 (23.8%)
Treatment Status	**n=27**
On HAART	24 (88.8%)
Not on HAART	3 (11.1%)
Total	27 (100%)
Treatment status was not documented for 14 (33.3%) and missing from 1 (2.4%) of all charts.	
CD4 Distribution	**n=17**
‹50/mm3	4 (23.5%)
50 – 199/mm3	2 (11.8%)
200 - 499/mm3	4 (23.5%)
› 500/mm3	7 (41.2%)
Total	17 (100%)
CD4 values were not documented for 25 (59.5%) of all charts	
Viral Load Distribution	**n=15**
Undetectable	0 (0%)
1 – 999 c/mL	4 (22.2%)
1000 – 6,999 c/mL	4 (22.2%)
7,000 -19,999 c/mL	3 (16.7%)
20,000 – 54,999 c/mL	2 (11.1%)
› 55,000 c/mL	5 (27.8%)
Total	15 (100%)
Viral load values were not documented for 24 (57.1%) of all charts	
Age Range	**Mean CD4 (mean % of total lymphocytes) n=16**
1 – 5 years (n=1)	1,153/mm3 (28%)
6 – 12 years (n=5)	466.6/mm3 (25.8%)
› 12 years (n=10)	276.5/mm3 (15.7%)
Age and CD4 values were documented for 16 of the 42 (38%) charts.	

Insurance status

All but one of the clients with a documented insurance source had Medicaid, although insurance status was not documented in more than one-half (57%) of the charts reviewed (Table 8).

Table 8. Insurance status

Insurance Status	n=42
No insurance	1 (2.4%)
Medicaid	17 (40.5%)
Not documented	24 (57.1%)

Residence

While ZIP code or residence was not documented in some of the charts (11.9%), most of the clients resided in Baltimore City (Table 9).

Table 9. ZIP code of residence

ZIP code/City	# (% of total)
Baltimore/ZIP code not documented	8 (19%)
Residence not documented in chart	5 (11.9%)
21205	3 (7.1%)
21202	2 (4.8%)
21213	2 (4.8%)
21216	2 (4.8%)
21218	2 (4.8%)
21224	2 (4.8%)
21229	2 (4.8%)
21045	1 (2.4%)
21061	1 (2.4%)
21122	1 (2.4%)
21133	1 (2.4%)
21201	1 (2.4%)
21207	1 (2.4%)
21208	1 (2.4%)
21214	1 (2.4%)
21215	1 (2.4%)
21217	1 (2.4%)
21222	1 (2.4%)
21225	1 (2.4%)
21234	1 (2.4%)
21244	1 (2.4%)

Comparison with Baltimore City EMA prevalence data[2]

In comparison with reported Baltimore City EMA HIV/AIDS prevalence, the sample of charts reviewed is more male and less African-American, although race/ethnicity was not documented in 12% of the reviewed charts (Table 10).

[2] Baltimore City Health Department, HIV Surveillance Program, "Baltimore City HIV/AIDS Epidemiological Profile," Third Quarter 2002. Prevalence data on September 30, 2001 as reported through September 30, 2002.

Table 10. Demographic comparison of client records reviewed with Baltimore City EMA prevalence

Population	Reviewed client records	Baltimore City HIV/AIDS prevalence
% Male (age 0-19 years)	60%	53%
% African-American	79%	88%

HRSA reporting categories

Client demographics by HRSA reporting categories are reported below.

Table 11. Proportion of client records reviewed by HRSA reporting category

Population	Reviewed client records
0 – 12 months	0%
1 – 12 years	38.1%
13 – 24 years	52.4%
Women >= 25 years	0%
African-American/Female	35.7%
African-American/Male	45.2%

Section 3. Client-level assessment of compliance with EMA standards of care

A. Initial Evaluation (Standard of Care 1.1)

The Standard of Care 1.1 focuses on the key components of initial evaluations for clients referred for mental health services. As part of the initial evaluation, a client history, mental status exam, cognitive, emotional and/or behavioral assessment and laboratory findings are to be assessed. In addition, a multi-axial diagnosis and treatment plan are to be identified and established. Based on the findings, care is to be rendered in a manner consistent with practice guidelines. A total of 22 clients entered treatment for mental health services during the review period, representing 52% of the total sample (n=42). Table 12 outlines agency compliance with the various components of the initial evaluation.

Table 12. Assessment of compliance with Standard of Care 1.1

EMA Standard	Percent of reviewed charts meeting Standards	
Initial evaluation must be conducted prior to the initiation of treatment. [Standard1.1]	50%	(n=22)
Initial evaluation must be conducted by licensed mental health professional working as part of an interdisciplinary team. [Standard1.1]	50%	(n=22)
Inclusion of a child psychiatrist or pediatrician on interdisciplinary team. [Standard1.1]	23%	(n=22)
Initial evaluation documents client history. [Standard1.1.a]	46%	(n=22)

Client history item	% included (n=10)
Chief complaint	100%
Family history	100%
Present illness	100%
Placement history	90%
Sibling and peer relations	80%
Medical history	70%
Social and emotional factors	70%
School history	60%
Review of any prior treatment and evaluations	40%
Current and recent medications	30%
Developmental history	30%
Prenatal and neonatal history	30%
Review of systems	30%
Premorbid functioning	10%
Mean percent completeness for all clients	**61%**

Only those charts with a client history (10 of 22) were included in the table above.

Initial evaluation documents developmentally appropriate mental status evaluation. [Standard 1.1.b]	32%	(n=22)
Initial evaluation documents cognitive, emotional and/or behavioral assessment. [Standard 1.1.c]	27%	(n=22)
Initial evaluation documents laboratory studies, as indicated. [Standard 1.1.d]	41%	(n=22)
Initial evaluation documents multi-axial differential diagnosis leading to final diagnostic formulation. [Standard 1.1.e]	23%	(n=22)

Development of treatment plan with specific measurable treatment goals through the appropriate use of outcome assessment. [Standard 1.1.f]	32%	(n=22)
Communication with patient's primary care provider/referral source at time of initial evaluation. [Standard 1.1.g]	23%	(n=22)
Specified treatment plan adheres to recognized treatment guidelines for the diagnosis category being treated. [Standard 1.1.g]	86%	(n=7)

Of the 22 clients who initiated mental health services during the review period, 50% had an initial evaluation completed (Standard 1.1)—all being conducted by a licensed mental health professional. According to Standard 1.1, the initial evaluation must be conducted by the licensed mental health professional working as part of an interdisciplinary team. In most cases (68%), the evaluation was conducted by one clinician, either a psychiatrist, psychologist, or social worker. For the remaining 7 cases (32%), a team (more than one provider) was used to perform the initial evaluation. Standard 1.1 defines team members as consisting of a pediatrician and/or child psychiatrist, licensed psychologist, nurse, and/or social worker.

Standard 1.1.a states that an initial evaluation must document a client history and specifies 14 items to assess. Ten of the 22 records (46%) contained a client history and consistently documented the chief complaint (100%), present illness (100%), family history (100%), and placement history (90%). Items with a low rate of completion included the following: premorbid functioning (10%), prenatal/neonatal history (30%), developmental history (30%), review of systems (30%), and current/recent medications (30%). On average, approximately 9 of the 14 assessment items were documented as part of the completed client histories.

As part of the initial evaluation, a developmentally appropriate mental status evaluation should also be completed (Standard 1.1.b). Of the 22 records reviewed, only 7 (32%) documented a mental status evaluation. Of those, 100% were age appropriate. A cognitive, emotional and/or behavioral assessment was documented in only 6 of the 22 records (27%) reviewed (Standard 1.1.c).

Laboratory studies, as indicated, were documented in the initial evaluation in 9 of the 22 records (41%) reviewed (Standard 1.1.d).

Standard 1.1.e states that an initial evaluation must document a multi-axial differential diagnosis leading to a final diagnostic formulation. Of the 22 records reviewed, only 23% documented a multi-axial differential diagnosis. The most frequent diagnoses for Axis I were relationship problems and mood disorders. There were no Axis II diagnoses documented. Axis III diagnoses focused primarily on HIV/AIDS and chronic medical illness. For Axis IV, the diagnoses documented were problems with the primary support group and problems related to the social environment. Only 4 clients had a documented Global Assessment of Functioning (GAF) on Axis V; the scores ranged from 65-80.

While treatment plans, with specific measurable goals, are to be established for all clients (Standard 1.1.f), only 7 records (32%) contained such treatment plans. All but one of these treatment plans adhered to recognized treatment guidelines for the diagnosis category being treated (Standard 1.1.g) and all of the treatment plans indicated age appropriate services.

In addition to outlining the expectation of care being provided in accordance with practice guidelines, Standard 1.1.g delineates expectations related to written communication between the primary care provider and the referral source. At a minimum, written communication should be completed at the time

of initial evaluation, at three month intervals and at time of discharge from mental health services. Of the 22 records that documented initiation of service during the review period, only 5 records (23%) contained written communication between the primary care provider and the referral source at the time of the initial evaluation. Referral sources were primarily internal. One third (33%) of the 42 records reviewed contained documentation of written communication with the patient's primary care provider/referral source every three months.

B. Standards of care for follow-up care and treatment (Standard of Care 1.2)

As with the "Initial Evaluation" Standards (1.1), Standard of Care 1.2 outlines a series of key activities related to the provision and monitoring of care and treatment over time. All records reviewed (n=42) were assessed for compliance with the standards relating to follow-up care and treatment. Table 13 outlines agency compliance with the various components of Standard 1.2. Additional information about sub-standards 1.2.a-1.2.f follow the table.

Table 13. Assessment of compliance with Standard of Care 1.2

EMA Standard	Percent of reviewed charts meeting Standards	
Documentation of treatment plan [Standard 1.1f]	52%	(n=42)
Documentation of visit frequency every week to two weeks for patients with active symptoms working toward a short term goal. For those whose symptoms are in remission but remain on psychotherapeutic medicines visits averaging every three months as necessary. [Standard 1.2.a]	55%	(n=42)
Documentation of monitoring of medications [Standard 1.2.c]	100% *5 clients were receiving medications as part of their mental health treatment.*	(n=5)
Documentation of side effect monitoring. [Standard 1.2.d]	80%	(n=5)
Documentation of medication administration training. [Standard 1.2.d]	20%	(n=5)
Documentation of monitoring of treatment plan goal attainment through the use of appropriate treatment outcome assessment. [Standard 1.2.e]	62%	(n=42)
Documentation of treatment plan reassessment at least every three months. [Standard 1.2.f]	0% *Of the 22 charts with treatment plans, 2 were excluded because the client received services for less than 3 months.*	(n=20)
Communication with patient's primary care provider/referral source at time regular review (three months intervals). [Standard 1.1.g]	33%	(n=42)

Formal treatment plans were documented in 22 of the 42 records (52%) (Standard 1.1.f).

Standard 1.2.a indicates the visit frequency should be based on the diagnosis, severity of need, and the treatment plan. For instance, patients with active symptoms should be seen every one to two weeks while clients whose symptoms are in remission but remain on psychotherapeutic medications should be monitored every 3 months. While 55% of the records reviewed documented appropriate visit frequency, a significant number (45%) did not meet the standard.

Note: Standard 1.2.b refers to the various modalities of treatment appropriate for the Standard's target population. Since this standard does not identify a quality indicator, this information was not abstracted during the chart review process.

Standards 1.2.c and 1.2.d focus on the prescription and monitoring of appropriate medication as indicated by the clinical situation, evidence-based practice guideline recommendations, and linkage to specific treatment goals. Standard 1.2.c states that prescription and monitoring of stimulant medications (e.g., Ritalin) and central antihypertensive medications used to treat ADHD (e.g., Clonidine) can be provided by a pediatrician, while psychotropic medications must be provided by a child psychiatrist.

Five of the 42 records reviewed (12%) indicated that medications were prescribed by the mental health provider, and all of these (100%) were prescribed by a child psychiatrist. The medications were all clinically appropriate and indicated by treatment guidelines. For the 5 clients prescribed medication, there was 100% compliance with the standard relating to the monitoring of medications.

Standard 1.2.d addresses side effect management and medication training for the child, adolescent and/or caregiver. Of the 5 records reviewed, 4 (80%) documented routine and appropriate side effect management for clients receiving psychotropic medications. The methods used to assess side effects included patient interviews, parent/caregiver interviews, and physical assessments of the patient.

A substantially fewer number of records contained documentation related to medication training. Of the 5 records reviewed, only 1 (20%) documented routine and developmentally appropriate patient teaching/education about medications. This record included one-to-one teaching by the health care team and materials given to the patient. Content documented in the record included the names of medications, proper times to administer the medications, expected benefits, and the importance of medication adherence. Teaching was provided by a pediatrician and a child psychiatrist.

Standard 1.2.e focuses on monitoring the patient's progress toward treatment goals through the use of appropriate outcome assessments, such as child self-reports, parent/caregiver self-reports and/or school reports. Of the 42 records reviewed, 26 (62%) documented the use of outcome assessments to monitor progress toward treatment goals. The most common method of assessment used was parent/caregiver report, followed by patient report. Other less frequently used methods include school reports and reports from other providers.

Almost half of the 42 records (45%) reviewed indicated that the client was making progress towards treatment goal attainment. For 17 of the records reviewed (41%), the lack of progress was documented by the mental health provider (Standard 1.2.f). Barriers to progress and issues identified included: non-adherence with medication/treatment (19%), lack of medication tolerability (12%), inadequate dosage (7%), change in patient stressors (19%) and medical co-morbidity (10%). Other barriers (26%) that were specified included the following: care provider resistance, caregiver resistance, lack of motivation, lack of support, lost to follow up, patient's disinterest, placement issues, substance abuse, and having too few clinical sessions to adequately assess barriers.

Standard 1.2.f outlines a three month time interval for reassessment of the treatment plan and assessment of progress made toward goal attainment. Of the 20 records that contained a treatment plan and were eligible for reassessment every three months, **no records documented reassessment.**

C. Termination and discharge planning

Of the 42 charts reviewed, 1 client completed care and 7 were terminated by the provider. Of the 7 terminated, 5 were terminated because of lack of attendance or interest in receiving treatment, 1 client was no longer in crisis, and 1 client died.

There are no specific Standards regarding termination and discharge planning. However, Standard 1.1.g states that written communication with the patient's primary care provider/referral source should take place at the time of termination of mental health services. None of the 7 charts reviewed documented communication with the primary care provider regarding the client's discharge from mental health services (Table 14).

Table 14. Assessment of compliance with Standard of Care 1.1g

EMA Standard	Percent of reviewed charts meeting Standards
Documentation of written communication to patient's primary care provider/referral source at time of discharge from mental health services. [Standard 1.1.g]	0% (n=7) *Of the 8 clients who either completed or terminated mental health services, 1 was excluded because of client death as the reason for termination.*

Additional data was collected regarding discharge planning and continuity of care. All but one of the clients who terminated/completed care (86%) received appropriate discharge planning. However, only 3 of the 7 clients (43%) were included in the discharge planning process.

Section 4. Agency-level assessment of compliance with EMA standards of care

As part of the QIP process, agencies providing mental health services to children and adolescents were asked to complete a five page survey. (See Appendix B for a copy of the agency survey.) The purpose of this survey was to document the self-reported compliance with the EMA's Operational and Performance Standards for Mental Health Services to Children and Adolescents pertaining to agency policies and procedures. All data presented is self-reported by the surveyed agencies and the QIP process did not verify the agencies' responses.

Table 15 lists the services directly provided by the agencies delivering mental health care to children and adolescents and those provided through referral agreements. The two agencies provide a large number of other services to clients and range from ambulatory health care to ancillary and supportive services, such as transportation and direct emergency assistance. The agencies also indicate having access to a wide array of services through referral agreements. Dental care is the only service which respondents are more likely to provide through referral than directly.

Table 15. Services provided directly by Mental Health Services to Children and Adolescents agencies or through referral agreements

Service category (n=2)	% which provide service directly	% with referral agreements
Case Management	100%	—
Client Advocacy	100%	—
Ambulatory Health Care	100%	—
Outreach	50%	50%
Transportation	50%	50%
Direct Emergency Assistance	50%	—
Viral Load Testing	50%	—
Mental Health Services	100%	—
Substance Abuse Treatment	50%	50%
Counseling	50%	
Housing Assistance	—	50%
Food/Nutrition	—	50%
Dental Care	—	100%
Co-morbidity Services	50%	—
Legal Services	—	50%
Buddy/Companion	50%	—
Enriched Life Skills	50%	—
Case Management Adherence	50%	—

Standards of Care

A. Licensing, Knowledge, Skills and Experience (Standard of Care 2.1)

Both agencies report 100% compliance with standards relating to staff licensing, knowledge, skills, and experience.

Compliance with each of the three standards within Licensing, Knowledge, Skills and Experience are presented below (Table 16).

Table 16. Agency-level assessment of compliance with Standard of Care 2.1

EMA Standard	Percent of agencies reporting compliance Standard	
All staff delivering mental health services will possess current organizational and professional licensure. [Standard 2.1.a]	100%	(n=2)
Non-licensed staff or trainees delivering mental health services will receive professional supervision of the care they are providing to individual patients/clients, by a licensed mental health provider. [Standard 2.1.b]	100%	(n=2)
All staff delivering mental health services will either have specific experience in caring for HIV-infected patients or receive appropriate training. [Standard 2.1.c]	100%	(n=2)

B. Patient Rights and Confidentiality (Standard of Care 2.2)

Both agencies report 100% compliance with policies and procedures relating to patient rights (Standard 2.2.a) and confidentiality (Standard 2.2.c). However, the agencies indicate that they do not have policies and procedures regarding the provision of culturally appropriate care to their patients (Standard 2.2.d).

Compliance with each of the four standards within Patient Rights and Confidentiality are presented below (Table 17).

Table 17. Agency-level assessment of compliance with Standard of Care 2.2

EMA Standard	Percent of agencies reporting compliance with Standard	
The provider organization will provide assurance and method of protection of patient rights in the process of care provision. [Standard 2.2.a]	100%	(n=2)
The provider organization will provide assurances and a method of protection of patient confidentiality, with regard to medical information transmission, maintenance and security. [Standard 2.2.b]	100%	(n=2)
In working with children, confidentiality must be broken, by State of Maryland law, if the provider feels that the child is in danger or in some way threatens someone else. [Standard 2.2.c]	100%	(n=2)
The provider organization will provide assurances regarding the provision of culturally appropriate care to their patients. [Standard 2.2.d]	0%	(n=2)

C. Access, Care and Provider Continuity (Standard of Care 2.[2])

Both agencies report a high degree of compliance with standards relating to access, care and provider continuity[3]. For Standard 2.[2].b[4], both agencies (100%) report providing mechanisms for urgent care, evaluation, or triage. For Standard 2.[2].e, both agencies (100%) indicate that they have developed and

[3] Standard 2.[2].a was not assessed as part of the agency survey.
[4] The Standards of Care misnumber standards relating to Access, Care and Provider Continuity. In this document, these standards are numbered 2[2].

maintained linkages with substance abuse treatment providers in order to maintain continuity for clients with dual diagnoses of substance use disorders and other mental disorders.

Standard 2.[2].c deals with access to the following services, if clinically indicated: therapeutic day care, therapeutic foster homes, day hospitals, residential treatment facilities, and inpatient psychiatric unit. Agencies report 100% compliance with the standard for therapeutic foster homes, day hospital, and inpatient psychiatric unit. There was 50% compliance for therapeutic day care and residential treatment facilities.

Standard 2.[2].d deals with the agency's mechanisms in place to ensure continuity of mental health/psychiatric care to their patients when they are in the following care settings: therapeutic day care, Level V school programs, day hospitals, substance abuse programs, residential treatment facilities, inpatient psychiatric units, inpatient units, rehabilitation hospitals, and hospice programs. There was 100% compliance with the standard for all treatment settings except one: there was 50% compliance for hospice programs.

Compliance with Access, Care and Provider Continuity Standards are presented below (Table 18).

Table 18. Agency-level assessment of compliance with Standard of Care 2.[2]

EMA Standard	Percent of agencies reporting compliance with Standard
The provider organization will provide mechanisms for urgent care evaluation or triage. [Standard 2.[2].b]	100% (n=2)
The provider organization will provide a mechanism to make available to it's [sic] patients/clients access, if clinically indicated, to the full range of mental health treatment settings including: ▪ therapeutic day care ▪ therapeutic foster homes ▪ day hospital ▪ residential treatment facilities ▪ inpatient psychiatric unit. [Standard 2.[2].c]	(n=2) ▪ therapeutic day care: 50% ▪ therapeutic foster homes: 100% ▪ day hospital: 100% ▪ residential treatment facilities: 50% ▪ inpatient psychiatric unit: 100%
The provider organization will provide mechanisms for continuity of mental health/psychiatric care to their patients [in] all settings in which they may receive care, including, but not limited to: ▪ therapeutic day care ▪ Level V school programs ▪ residential treatment facilities ▪ day hospitals ▪ substance abuse programs ▪ inpatient psychiatric units ▪ inpatient medical units ▪ rehabilitation hospitals ▪ hospice programs [Standard 2.[2].d]	(n=2) ▪ therapeutic day care: 100% ▪ Level V school programs: 100% ▪ residential treatment facilities: 100% ▪ day hospitals: 100% ▪ substance abuse programs: 100% ▪ inpatient psychiatric units: 100% ▪ inpatient medical units: 100% ▪ rehabilitation hospitals: 100% ▪ hospice programs: 50%
The provider organization will develop and maintain linkages with substance abuse treatment providers, such as to maintain continuity for patients with dual diagnosis of substance use disorders and other mental disorders. [Standard 2.[2].e]	100% (n=2)

D. Quality Improvement (Standard of Care 2.4)

One of the 2 agencies reports that it is in compliance with Standard 2.4.a and 2.4.b relating to a quality improvement program. Both agencies indicate having a process for clients to evaluate the agency, staff, and services.

Compliance with two standards within quality improvement is presented below (Table 19).

Table 19. Agency-level assessment of compliance with Standard of Care 2.4

EMA Standard	Percent of agencies reporting compliance with Standard	
The provider organization will provide for methods to monitor for areas in need of improvement. [Standard 2.4.a]	50%	(n=2)
The provider organization will provide methods for the development of corrective action and the assessment of the effect of such actions, regarding areas in need of improvement. [Standard 2.4.b]		

Section 5. Discussion

The QIP process provided a systematic review of compliance to the EMA's Standards of Care for 100% of Mental Health Services to Children and Adolescents providers (n=2) receiving Title I funds during FY2001. A total of 42 records were reviewed, representing approximately 23% of the reported Title I children and adolescent mental health clients served in the Baltimore EMA.

The following items have a higher rate of compliance with the Standards of Care:

- All clients who were receiving psychotropic medications were being monitored by a child psychiatrist. The medications were all clinically appropriate and indicated by treatment guidelines.

- Of clients receiving psychotropic medications, 80% had routine and appropriate side effect management documented. Various methods were used to assess side effects, such as patient interviews, physical assessments and parent/caregiver interviews.

- Fifty-five percent (55%) of clients had visit frequencies that were appropriate based on diagnosis, severity of need, and treatment plan. All but one of these treatment plans adhered to recognized treatment guidelines for the diagnosis category being treated (Standard 1.1.g) and all of the treatment plans indicated age appropriate services.

- Of the 42 records reviewed, 62% documented the use of outcome assessments to monitor progress toward treatment goals.

- Eighty six percent (86%) of the clients who terminated/completed care received appropriate discharge planning.

- Both agencies (100%) provide a large number of services to clients in addition to mental health care. These services are provided directly as well as by referral.

- Both agencies (100%) report having a process for clients to evaluate the agency, staff, and services.

This review of QIP data identifies several areas where there is a lower rate of compliance with the Standards of Care. The most notable areas are discussed below and include:

1. Initial client evaluations;
2. Development and reassessment of treatment plans;
3. Visit frequency; and
4. Communication with primary care providers.

In respect to initial evaluations, half (50%) of the clients who initiated mental health services during the review period did not receive a baseline evaluation. Of those that had an evaluation completed, slightly more than half (64%) of the assessment items were consistently completed as specified by the Standards. Less than one-quarter (23%) had a multi-axial differential diagnosis documented and only 30% documented the patient's current or recent medication regimen.

Treatment plans were not consistently used by either agency. Slightly more than half (52%) of the records reviewed documented formal treatment plans. A substantially smaller number (32%) of treatment

plans were documented for clients who had an initial evaluation conducted during the review period. Once in place, treatment plans were not assessed as specified. None (0%) of the records documented appropriate re-evaluation of the plan.

While 55% of the records reviewed documented appropriate visit frequency based on diagnosis, severity of need and treatment plan, a significant number (45%) did not meet the Standard. Combined with the low rates of communication with the client's primary care provider and/or referral source at initial evaluation (23%), at three months (33%) and at discharge (0%), the potential for clients to disengage or drop out of care is significant. It is unclear if formal policies and procedures are established to track and re-engage clients who have missed appointments and are considered lost to follow-up.

Overall, both agencies report a high degree of compliance with Standards relating to agency policies and procedures regarding licensing, knowledge, skills and experience. With one exception, agencies report a high degree of compliance with Standards relating to patient rights and confidentiality. Neither agency indicated that they have policies and procedures regarding the provision of culturally appropriate care to their patients, although one indicated that this issue is consistently discussed among staff. Both agencies report a high degree of compliance with Standards relating to access, care, and provider continuity. A lower degree of compliance was reported for Standards related to quality improvement. One agency reported that a quality improvement program was not currently established.

Section 6. Recommendations

The primary recommendations for Mental Health Services to Children and Adolescents focus on three areas: 1) priority areas for quality improvement projects; 2) review and revision of the Standards of Care; and 3) development of quality indicators for Mental Health Services to Children and Adolescents.

Priority Areas for Quality Improvement Projects

As previously identified, the most notable issues related to the provision of Mental Health Services to Children and Adolescents focus on four main areas: 1) initial client evaluations; 2) development and reassessment of treatment plans; 3) visit frequency; and 4) communication with primary care providers. As the EMA and individual vendors identify quality improvement projects to undertake, these four areas can be incorporated into these projects.

Review and Revision of the Standards of Care

As an initial step in the quality improvement process, it might be beneficial to review the Standards of Care to clarify the minimum expectations of service delivery, identify components that are not currently addressed and revise them as appropriate. Within the currently published Standards, specific examples of items that are not currently addressed in the Standards include the following: 1) discharge planning; 2) documentation of failed/cancelled or missed appointments; 3) follow-up of clients lost to care; and 4) policies and procedures for termination or closing of cases.

The Standards should also specify the client-level data providers should be expected to document not only as part of the initial assessment but also to regularly update. These include:

- HIV-transmission risk
- CD4 value
- Viral load
- Current medications, including antiretroviral therapy
- Current primary medical care provider
- Case manager/case management agency
- Insurance status

Additionally, it may be beneficial to expand the routine reporting requirements to include type of treatment modalities provided and more client-specific utilization data that can be used to monitor trends.

Quality Indicators

As the Standards are revised, incorporation of quality indicators is integral to the quality improvement process. By identifying the core indicators to track and trend, the expectations regarding service delivery are further clarified. Based on the review of the Standards and the data collected as part of the QIP review process, the recommended core quality indicators to track as part of Mental Health Services to Children and Adolescents are identified in Table 20. Target performance goals have also been identified in this table, but the actual goal should be finalized in conjunction with BCHD and the Planning Council.

Table 20. Recommended Quality Indicators for Mental Health Services to Children and Adolescents

Quality Indicator [Reference]	EMA Mean Performance	Performance Goal
% of client records which document completion of initial evaluation by a licensed mental health professional, working as part of an interdisciplinary team prior to the initiation of treatment. [Standard 1.1]	50%	90%
% of client records which document completion of multi-axial differential diagnosis leading to final diagnostic formulation. [Standard 1.1.e]	23%	80%
% of client records which document completion of treatment plan [with specific measurable treatment goals through the appropriate use of outcome assessment] [Standard 1.1.f]	32%	90%
% of client records which document reassessment of the treatment plan and progress by the interdisciplinary team every three months. [Standard 1.2.g]	0%	80%
% of client records which document medication administration training and side effect monitoring to patient/caregiver of the child and developmentally appropriate medication information to the child. [Standard 1.2.d]	20%	80%
% of client records which document written communication with patient's primary care provider/referral source at the time of initial evaluation and at points of regular review (three month intervals), and at time of discharge from mental health services. [Standard 1.1.g]	initial: 23% discharge: 0%	80%

Appendices

- Appendix A. Client Chart Abstraction Instrument: Mental Health Services: Children and Adolescents
- Appendix B. Agency Survey: Mental Health Services: Children and Adolescents
- Appendix C. Operational and Performance Standards for Mental Health Services to Children and Adolescents, ratified October 1997; revised September 1999. Greater Baltimore HIV Health Services Planning Council. http://www.baltimorepc.org

BCHD Quality Improvement Project
Mental Health Services: Children and Adolescents
Client Chart Abstraction

Instructions

Complete this instrument for children and adolescents, ages birth through 18. For clients 18 years or older at time of intake, use the Mental Health Services: Adult Client Chart Abstraction instrument. Note: References to client may refer to both/either the client and his/her parent/caregiver.

Section 1. Reviewer Information

Instructions: Complete the requested information.

1.1	Date of review	
1.2	Name of reviewer	
1.3	Client chart ID#	
1.4	Time start chart review	
1.5	Time end chart review	
1.6	Total time for chart review (hrs:min)	
1.7	Chart start date (Date of first entry in client chart)	
1.8	Chart end date (Date of last entry in client chart)	
1.9	Dates of services reviewed in chart	☐ 3/1/01 to 2/28/02 (Default) ___ / ___ / _____ to ___ / ___ / _____
1.10	Was chart **opened/ initiated** mental health services during review period?	☐ Yes ☐ No; mental health services initiated prior to review period ☐ Not documented in chart
1.11	Was **chart closed/client terminated** from mental health services during review period?	☐ Yes ☐ No; client continued to receive mental health services throughout review period ☐ Not documented in chart

Section 2. Client Demographics

Instructions: Provide the requested information based on information contained in the client's chart.

2.1	Date of birth	___ / ___ / _____ ☐ Age on 2/28/02 if no dob in chart ____ ☐ Not documented in chart
2.2	Gender	☐ Male ☐ Female ☐ Transgender ☐ Not documented in chart
2.3	Race/Ethnicity	☐ White ☐ Black/African-American ☐ Hispanic/Latino/a ☐ Asian/Pacific Islander ☐ American Indian/Alaska Native ☐ African ☐ Caribbean ☐ Other: Specify: ☐ Not documented in chart
2.4	HIV risk factor *[Check all that apply]*	☐ Men who have sex with men (MSM) ☐ Injecting drug user (IDU) ☐ MSM and IDU ☐ Heterosexual contact ☐ Heterosexual contact and IDU ☐ Hemophilia/coagulation disease or receipt of blood products ☐ Undetermined/unknown, risk not reported ☐ Perinatal transmission ☐ Other: Specify: ☐ Not documented in chart
2.5	Zip code client residing in on 3/1/01 (or first entry In review period)	_____ City, if no zip code indicated: ☐ Not documented In chart

2.6.a	Client health insurance on 3/1/01 (or first entry in review period) *[Check all that apply]*	☐ None ☐ Medicaid ‹See list of Medicaid MCOs› ☐ CHIPS ☐ Maryland AIDS Drug Assistance Program ☐ Maryland Pharmacy Assistance Program ☐ Maryland Primary Care Program ☐ Medicare ☐ Private/Commercial ☐ Veteran's Administration ☐ Corrections ☐ Unknown [client reports not knowing] ☐ Other: Specify: ☐ Not documented in chart

List of Maryland's HealthChoice Medicaid MCOs

AMERICAID Community Care
Helix Family Choice
Jai Medical Systems
Maryland Physicians Care
Priority Partners
United HealthCare

2.6.b	Client health insurance on 2/28/02 (or last entry in review period) *[Check all that apply]*	☐ None ☐ Medicaid ‹See list of Medicaid MCOs› ☐ CHIPS ☐ Maryland AIDS Drug Assistance Program ☐ Maryland Pharmacy Assistance Program ☐ Maryland Primary Care Program ☐ Medicare ☐ Private/Commercial ☐ Veteran's Administration ☐ Corrections ☐ Unknown [client reports not knowing] ☐ Other: Specify: ☐ Not documented in chart

2.7.a	HIV-disease status on 3/1/01 (or first entry in review period)	☐ HIV-positive, not AIDS Date of dx: ___/___/ ____ ☐ Date not documented in chart ☐ CDC defined AIDS Date of dx: ___/___/ ____ ☐ Date not documented in chart ☐ Not documented in chart	Pediatric HIV Classification: ☐ Not documented in chart
2.7.b	HIV-disease status on 2/28/02 (or last entry in review period)	☐ Deceased Date of death: ___/___/ _____ ☐ Date not documented in chart ☐ HIV-positive, not AIDS Date of dx: ___/___/ _____ ☐ Date not documented in chart ☐ CDC defined AIDS Date of dx: ___/___/ _____ ☐ Date not documented in chart ☐ Not documented in chart	Pediatric HIV Classification: ☐ Not documented in chart

2.8.a	CD4/Viral Load 3/1/01 (or first entry in review period)	CD4 _____ cells/uL _____ % Date of test: ___/___/ _____ ☐ Date not documented in chart Viral load: _____ Date of test: ___/___/ _____ ☐ Date not documented in chart ☐ Not documented in chart	**ⓘ Source:** ☐ Documented patient self report ☐ Copy of lab report in chart ☐ Communication from medical provider (e.g., letter, medical encounter progress note) ☐ Patient flow sheet in chart ☐ Other/specify:
2.8.b	CD4/Viral Load 2/28/02 (or last entry in review period)	CD4 _____ cells/uL _____ % Date of test: ___/___/ _____ ☐ Date not documented in chart Viral load: _____ Date of test: ___/___/ _____ ☐ Date not documented in chart ☐ Not documented in chart	**ⓘ Source:** ☐ Documented patient self report ☐ Copy of lab report in chart ☐ Communication from medical provider (e.g., letter, medical encounter progress note) ☐ Patient flow sheet in chart ☐ Other/specify:
2.9.a	Client on HAART 3/1/01 (or first entry in review period)	☐ Yes ☐ No ☐ Treatment not documented in chart **ⓘ Source:** ☐ Documented patient self report ☐ Copy of medication sheet from medical provider ☐ List of medications maintained by case manager ☐ Communication from medical provider (e.g., letter, medical encounter progress note) ☐ Other/specify:	
2.9.b	Client on HAART 2/28/02 (or last entry In review period)	☐ Yes ☐ No ☐ Treatment not documented in chart **ⓘ Source:** ☐ Documented patient self report ☐ Copy of medication sheet from medical provider ☐ List of medications maintained by case manager ☐ Communication from medical provider (e.g., letter, medical encounter progress note) ☐ Other/specify:	

Section 3. Initial Evaluation

Instructions: This section is to be completed only for clients who had an initial evaluation completed during the review period—March 1, 2001 to February 28, 2002.

☐ Initial evaluation completed before March 1, 2001 ▶ GO TO Section 4.0, page 10

☐ Client initiated mental health services after March 1, 2001 [and before February 28, 2002], but initial evaluation was not completed ▶ GO TO Section 4.0, page 10

☐ Initial evaluation completed after March 1, 2001 [and before February 28, 2002].

❶ Date of referral for services:

❷ Referral made by:

- ☐ Agency/specify:
- ☐ Self
- ☐ Family
- ☐ Child welfare system
- ☐ School system
- ☐ Criminal justice system
- ☐ Other/Specify

☐ Source of referral not documented in chart:

❸ Date evaluation began	❹ Date completed
☐ Chart does not provide this information.	☐ Chart does not provide this information.

	Review item	Documentation
3.a	Initial evaluation must be conducted prior to the initiation of treatment. *[MHCA Standard1.1]*	☐ Yes, chart contains evidence that initial evaluation was completed prior to treatment initiation. ☐ Evaluation completed after treatment initiated. ☐ No evaluation was completed. ▶ GO TO Section 4.0, page 10 ☐ Other/Specify:
3.b	Initial evaluation must be conducted by licensed mental health professional working as part of an interdisciplinary team. *[MHCA Standard1.1]*	What discipline(s) conducted the initial evaluation? ☐ Child psychiatrist ☐ Pediatrician ☐ Psychologist ☐ RN ☐ MSW/LCSW ☐ CPC/LPC-AD ☐ CAC ☐ Information not provided. ☐ Other/Specify:

3.c	Interdisciplinary team composition *[MHCA Standard1.1]*	❶ Does chart document care being provided by an interdisciplinary team? ☐ Yes, interdisciplinary team indicated. ☐ No, care not being provided by an interdisciplinary team. ☐ Information not provided. ❷ Is a Pediatrician and/or Child psychiatrist part of the service providing team? ☐ Yes, chart documents participation of Pediatrician and/or Child psychiatrist. ☐ No, care not being provided by a Pediatrician and/or Child psychiatrist. ☐ Information not provided. ❸ What disciplines are part of the interdisciplinary team? [Check all that apply.] ☐ Child psychiatrist ☐ Pediatrician ☐ Psychologist ☐ RN ☐ MSW/LCSW ☐ CPC/LPC-AD ☐ CAC ☐ Information not provided. ☐ Other/Specify:
3.d	Initial evaluation documents client history *[MHCA Standard1.1.a]*	☐ Yes, chart contains evidence that evaluation documents client history. ‣ Check areas documented in client history: ☐ Chief complaint ☐ Present illness ☐ Prenatal and neonatal history ☐ Developmental history—including milestones ☐ Social and emotional factors of infancy and childhood ☐ Family history ☐ Medical history ☐ Premorbid functioning ☐ Review of systems ☐ Current and recent medications ☐ School history ☐ Sibling and peer relations ☐ Placement history (e.g., foster care, kinship care) ☐ Review of any prior treatment and evaluations ☐ No, chart does not document a client history.
3.e	Initial evaluation documents developmentally appropriate mental status evaluation *[MHCA Standard 1.1.b]*	☐ Yes, chart contains evidence that evaluation documents mental status. ‣ Is the evaluation appropriate for the child/adolescent's age and stage of developments? ☐ Yes ☐ No ☐ No, chart does not document a mental status evaluation.

3.f	Initial evaluation documents cognitive, emotional and/or behavioral assessment *[MHCA Standard 1.1.c]*	☐ Yes, chart contains evidence that evaluation documents cognitive assessment. ❶ ▸ Check areas documented in cognitive assessment: ☐ Formal standardized (neuro)psychological tests: ☐ Developmental assessment ☐ Intellectual assessment ☐ Achievement testing ☐ Personality testing ☐ Neuropsychological testing ☐ Parent/patient self-report of behavioral and/or emotional measures. ❷ Who conducted the evaluation: ☐ Psychologist ☐ Psychological Assistant/Intern/Student ☐ Other:/specify: ☐ Information not provided. ☐ No, chart does not document a cognitive assessment.
3.g	Initial evaluation documents laboratory studies, as indicated. *[MHCA Standard 1.1.d]*	☐ Yes, chart contains evidence that evaluation documents laboratory studies, as indicated. ☐ No, chart does not contain evidence that standard was met. **Check whether laboratory study was clinically indicated for patient and whether it was performed during the initial evaluation.**

Study	Indication	Performed
Blood Alcohol Level	☐ Indicated ☐ Not indicated	☐ Yes ☐ No
Toxicologies	☐ Indicated ☐ Not indicated	☐ Yes ☐ No
Liver Panel	☐ Indicated ☐ Not indicated	☐ Yes ☐ No
Renal Panel	☐ Indicated ☐ Not indicated	☐ Yes ☐ No
Thyroid Function	☐ Indicated ☐ Not indicated	☐ Yes ☐ No
B-12/Folate	☐ Indicated ☐ Not indicated	☐ Yes ☐ No
Medication levels	☐ Indicated ☐ Not indicated	☐ Yes ☐ No
Other/Specify	☐ Indicated ☐ Not indicated	☐ Yes ☐ No

3.h	Initial evaluation documents multi-axial differential diagnosis leading to final diagnostic formulation *[MHCA Standard 1.1.e]* Axis I: Clinical disorders; other conditions that may be a focus of clinical attention	❶ Does chart document a multi-axial diagnosis consistent with initial evaluation findings? ☐ Yes, chart does document a multi-axial diagnosis developed from evaluation data. ☐ No, chart does not document a multi-axial diagnosis developed from evaluation data. *This question (3.h) continues on next page.* ⇢

	Axis II: Personality disorders; mental retardation Axis III: General medical conditions Axis IV: Psychosocial and environmental problems Axis V: Global Assessment of Functioning (GAF) 100-91: Superior 90-81: Absent/minimal 80-71: Transient/expectable 70-61: Mild symptoms 60-51: Moderate symptoms 50-41: Serious symptoms 40-31: Some/major impairment in several areas 30-21: Delusions/hallucinations; inability to function in most areas 20-11: Some danger of hurting self/others; occasionally fails to maintain personal hygiene; inability to function in all areas 10-1: Persistent danger of severely hurting self or others; persistent inability to maintain personal hygiene; or serious suicidal act with clear expectation of death	Documented diagnosis: Axis I: Axis II: Axis III: Axis IV: Axis V: ▸ Current GAF: ☐ GAF not documented ▸ Highest GAF in prev. 12 months: ☐ GAF not documented
3.i	Development of treatment plan with specific measurable treatment goals through the appropriate use of outcome assessment. *[MHCA Standard 1.1.f]*	❶ Does chart contain a treatment plan developed from the data collected during the initial evaluation? ☐ No, chart does not contain a care plan developed from initial evaluation data. ▸ GO TO Section 4.0, page 10 ☐ Yes, chart contains a care plan developed from initial evaluation data. ▸ CONTINUE ❷ Does treatment plan contain specific, measurable treatment goals? ☐ Yes, care plan contains specific, measurable treatment goals. ☐ No, care plan does not contain specific, measurable treatment goals. ❸ Does treatment plan contain method of outcome assessment to be used? ☐ Yes, care plan contains method of outcome assessment to be used. ☐ No, care plan does not contain method of outcome assessment to be used. ❹ Does treatment plan address issues relating to patient's HIV-related care and/or status? ☐ Yes ☐ No ❺ Does care plan address other issues of concern to the patient (e.g., school, nutrition, medical care?) ☐ Yes: ▸ Check how care plan addresses these issues: ☐ Care plan contains specific goals/outcomes relating to these issues for mental health services provider to address. ☐ Care plan indicates referral/collaboration with a case manager to address these issues. ☐ No, care plan addresses only the identified mental health related issues. ☐ Other/Specify

3.j	Communication with patient's primary care provider/referral source at time of initial evaluation *[MHCA Standard 1.1.g]*	Does chart include written communication to the patient's primary care provider/referral source at time of initial evaluation regarding the evaluation and treatment plan? ☐ Yes ☐ No

3.k **Treatment Plan**

Specify all modalities of treatment included in the treatment plan:

a) Modality	b) Provider (Note: "by agency" refers to agency being reviewed; note external agency client was referred to, when applicable.)	c) Date Service began*	d) Check if terminated during review period/Date of termination
☐ Individual Play Therapy	☐ by agency ☐ by referral to:		☐
☐ Therapeutic Play Groups	☐ by agency ☐ by referral to:		☐
☐ Parent/Child Therapy	☐ by agency ☐ by referral to:		☐
☐ Parent/Caregiver Therapy groups	☐ by agency ☐ by referral to:		☐
☐ Social Skills Groups	☐ by agency ☐ by referral to:		☐
☐ Family Therapy	☐ by agency ☐ by referral to:		☐
☐ School-Based Consultation	☐ by agency ☐ by referral to:		☐
☐ Grief/Bereavement Therapy	☐ by agency ☐ by referral to:		☐
☐ Individual Therapy	☐ by agency ☐ by referral to:		☐
☐ Group Therapy	☐ by agency ☐ by referral to:		☐
☐ Other/specify	☐ by agency ☐ by referral to:		☐

*If service was not provided, then write "NOT PROVIDED"; note reason service was not provided, if documented.

3.l	Plan of care is consistent with practice guidelines *[MHCA Standard 1.1.g]*	❶ Does treatment plan adhere to recognized treatment guidelines for the diagnosis category being treated? ☐ Yes ☐ No ❷ Are planned therapeutic services age-appropriate? ☐ Yes ☐ No

Section 4. Provision of Services

Instructions: This section is to be completed for all clients. Instructions: Review only documentation of services provided during the review period, March 1, 2001 to February 28, 2002.

▶ This section is to be completed for all clients

4.a	Treatment plan	Does chart contain a treatment plan for the client? ☐ Yes, chart contains a treatment plan. ☐ No, chart does not contain a treatment plan.
4.b	Documentation of frequency of visits *[MHCA Standard 1.2.a]*	❶ Does chart contain documentation of patient visits? ☐ Yes, chart **does** contain documentation of patient visits. (e.g., progress notes/encounter data for each patient visit to provider.) ☐ No, chart d**oes not** contain documentation of patient visits. ❷ Does chart contain documentation of visit frequency that is appropriate, based on the diagnosis, severity of need and treatment plan? (e.g., if condition is not yet stable, are appointments documents every 1 to 2 weeks; are medications being monitored every 3 months). ☐ Yes, chart **does** contain documentation of visit frequency that is based on diagnosis, severity of need, and treatment plan. ☐ No, chart **does** not contain documentation of visit frequency that is based on diagnosis, severity of need, and treatment plan.
4.c	Documentation of provision of supportive and educational counseling at all visits. "This should include counseling regarding the prevention of HIV-transmitting behaviors and substance abuse."	❶ Supportive and educational counseling ☐ Yes, chart **does** contain documentation of provision of supportive and educational counseling on each visit. ☐ No, chart **does not** contain documentation of provision of supportive and educational counseling on each visit. ☐ Not applicable: Not developmentally/age appropriate for this client. ❷ HIV prevention counseling ☐ Yes, chart **does** contain documentation of provision counseling regarding prevention of "HIV transmitting behaviors." ☐ No, chart **does not** contain documentation of provision counseling regarding prevention of "HIV transmitting behaviors." ☐ Not applicable: Not developmentally/age appropriate for this client. ❸ Substance abuse counseling ☐ Yes, chart **does** contain documentation of provision counseling regarding "substance abuse. ☐ No, chart **does not** contain documentation of provision counseling regarding "substance abuse. ☐ Not applicable: Not developmentally/age appropriate for this client.
4.d	Documentation of monitoring of medications *[MHCA Standard 1.2.c]*	❶ Are medications prescribed by the mental health provider? ☐ No. ▶ GO TO Section 4.f, page 12 ☐ Yes ▶ CONTINUE *This question (4.d) continues on next page.* ⇢

	❷ Is the patient receiving psychotropic medications? ☐ Yes: ▸ Are these prescribed and monitored by a child psychiatrist? ☐ Yes ☐ No ☐ Information not provided. ☐ No ❸ Are medications prescribed by the mental health provider clinically appropriate and indicated by treatment guidelines? ☐ Yes ☐ No
4.e Documentation of medication administration training and side effect monitoring. *[MHCA Standard 1.2.d]*	❶ Does chart contain documentation of routine and appropriate side-effect assessment? ☐ Yes ▸ Indicate methods used (check all that apply): ☐ Laboratory monitoring ☐ Patient interview ☐ Parent/caregiver interview ☐ Patient physical assessment ☐ Other/Specify: ☐ No ❷ Does chart contain documentation of routine and appropriate teaching patient about medications? ☐ Yes ▸ Indicate methods used (check all that apply): ☐ 1:1 teaching by health care team. ☐ Materials given to patient. ☐ Referring patient to educator or group sessions. ☐ Other/Specify: ▸ Indicate content documented (check all that apply): ☐ Names of medications. ☐ Proper times to administer medications. ☐ Expected benefit of medications. ☐ Common and potentially serious side-effects of medications. ☐ Importance of medication adherence. ▸ Indicate who provided training (check all that apply): ☐ Pediatrician ☐ Child Psychiatrist ☐ Nurse ☐ Other/Specify ☐ Information not provided. ☐ No *This question (4.e) continues on next page.* ⇢

	❸ Is information regarding medications provided to the child/adolescent? ☐ Yes ▸ Is this information provided in an age and developmentally appropriate format? ☐ Yes ☐ No ☐ Information not provided. ☐ No
4.f Documentation of monitoring of treatment plan goal attainment through the use of appropriate treatment outcome assessment. Inclusion of patient in monitoring. *[MHCA Standard 1.2.e]*	❶ Does the chart document objective monitoring of progress toward treatment goals? ☐ Yes, chart does contain documentation of objective progress. ▸ Indicate how progress is monitored(check all that apply): ☐ Parent/caregiver report ☐ Patient self-report ☐ School report ☐ Report from other provider/Specify: ☐ Objective measurement with rating scales ☐ Clinician observation during clinic/office visit ☐ Clinician observation during home visit ☐ No, chart does not document progress. ❷ Is the client making progress toward treatment goal attainment? ☐ Yes, provider indicates that client is making progress. ☐ No, provider indicates that client is not making progress. ▸ Indicate barrier(s) to progress identified by provider (check all that apply): ☐ Non-adherence with medication/treatment ☐ Lack of medication tolerability or medication adverse effects ☐ Inadequate dosage/need to adjust dosage ☐ Change in patient stressors ☐ Medical co-morbidity ☐ Other/Specify ☐ Chart does not document reasons for lack of progress.
4.g Documentation of care plan reassessment at least every three months. *[MHCA Standard 1.2.f]*	❶ Does chart contain a care plan for the client? ☐ **No,** chart does not contain a care plan. ▸ GO TO 4.h ☐ **Yes,** chart contains a care plan. Number of months of service provision during review period: (March 1, 2001 to February 28, 2002) ____ Number of reassessments documented: ____ *This question (4.g) continues on next page.* ⇢

		❷ Does chart contain documentation that care plan was reassessed at least every three months during the period of service provision? ☐ **No,** chart does not contain any documentation of reassessment. ▸ GO TO 4.h ☐ **Not applicable:** Client received services less than three months, so a reassessment was not indicated. ▸ ☐ Check here, if treatment plan was reassessed during the first three months of service provision. ▸ GO TO 4.h ☐ **Yes,** chart contains documentation of reassessment. ▸ GO TO 4.h ❸ Was the reassessment conducted by an interdisciplinary team? ☐ Yes. ☐ No. ☐ Information not provided. ❹ Based on the documentation in the chart, should the reassessment of the care plan have led to development of new goals/objectives/ outcomes? ☐ Yes, care plan content needed to be updated based on the documentation in the client chart. ▸ Was care plan? ☐ Appropriately updated; new goals/objectives outcomes established as indicated. ☐ Not updated as indicated. ☐ No, initial/previous care plan content was still appropriate.
4.h	Communication with patient's primary care provider/referral source at time regular review (three months intervals). *[MHCA Standard 1.1.g]*	Does chart contain documentation of written communication with the patient's primary care provider/referral source every three months? ☐ Yes. ☐ No.
4.i	Discharge planning/continuity of care	❶ Did client complete/was terminated from a mental health services during the review period? ☐ No. Client continued to receive services. ■ END OF CHART REVIEW ☐ Information not provided. ■ END OF CHART REVIEW ☐ Yes. Client completed/was terminated. ▸ ☐ Client completed treatment services. ☐ Client was terminated from treatment services. ▸▸ State reason for termination: ☐ Reason for termination not documented. *This question (4.i) continues on next page.* ⇢

	❷ Does chart contain documentation of appropriate discharge planning for client? ☐ Yes ☐ No ❸ Does chart contain documentation of inclusion of client in discharge planning? ☐ Yes ☐ No ❹ Does chart contain documentation of adequate follow-up/aftercare/ contingencies? ☐ Yes ☐ No ❺ Does chart contain documentation of appropriate referrals to primary care? ☐ Yes ☐ No ☐ Not applicable**:** Client already successfully linked to primary care ❻ Does chart contain documentation of appropriate referrals to case management? ☐ Yes ☐ No ☐ Not applicable: Client already successfully linked to case management ❼ Does chart contain documentation of appropriate referrals to ancillary care? ☐ Yes ☐ No ☐ Not applicable. Referrals not indicated. ❽ Does chart contain documentation of written communication to patient's primary care provider/referral source at time of discharge from mental health services? *[MHCA Standard 1.1.g]* ☐ Yes ☐ No

BCHD Quality Improvement Project
Mental Health Services: Children and Adolescents
Agency Survey

- Agency Name:
- Address:
- Person completing form:
- Telephone:
- Fax:
- E-mail:

Please check all of the services that your agency **directly provided,** on-site during Title I fiscal year 2001 (March 1, 2001-February 28 , 2002). **Note**: Do not limit your responses only to services funded by Ryan White Care Act.

- ☐ Ambulatory Health Care
- ☐ Outreach
- ☐ Substance Abuse Treatment
  - ☐ Inpatient Detoxification
  - ☐ Outpatient Detoxification
  - ☐ Long-term Structured Program
  - ☐ LAMM
  - ☐ Methadone
  - ☐ 12-step Programs
  - ☐ Individual counseling
  - ☐ Other_____
- ☐ Transportation
- ☐ Buddy/Companion
- ☐ Case Management
- ☐ Case Management Adherence
- ☐ Client Advocacy
- ☐ Counseling
- ☐ Dental Care
- ☐ Direct Emergency Assistance
- ☐ Food/Nutrition
- ☐ Housing Assistance
- ☐ Legal Services
- ☐ Enriched Life Skills
- ☐ Co-morbidity Services
- ☐ Viral Load Testing
- ☐ Other/Specify:

Please check all of the services that your agency does not directly provide on-site, but have **established (written) referral agreements** with other agencies to provide these services to your clients during Title I fiscal year 2001 (March 1, 2001-February 28 , 2002). **Note**: Do not limit your responses only to services funded by Ryan White Care Act.

- ☐ Ambulatory Health Care
- ☐ Outreach
- ☐ Substance Abuse Treatment
  - ☐ Inpatient Detoxification
  - ☐ Outpatient Detoxification
  - ☐ Long-term Structured Program
  - ☐ LAMM
  - ☐ Methadone
  - ☐ 12-step Programs
  - ☐ Individual counseling
  - ☐ Other_____
- ☐ Transportation
- ☐ Buddy/Companion
- ☐ Case Management
- ☐ Client Advocacy
- ☐ Counseling
- ☐ Mental Health Services
- ☐ Dental Care
- ☐ Direct Emergency Assistance
- ☐ Food/Nutrition
- ☐ Housing Assistance
- ☐ Legal Services
- ☐ Enriched Life Skills
- ☐ Co-morbidity Services
- ☐ Viral Load Testing
- ☐ Other/Specify:

Standards of Care

A. Licensing, Knowledge, Skills and Experience

1. Do all staff involved in the delivery of mental health services have the appropriate and current professional licensure from the state of Maryland?
   ☐ Yes ☐ No

2. Do all non-licensed staff and trainees delivering mental health services receive professional supervision by licensed mental health providers?

   ☐ Yes ☐ No

3. Do all mental health treatment staff have either specific experience in caring for HIV-infected patients or receive appropriate training?

   ☐ Yes ☐ No

B. Patient Rights and Confidentiality

4. Does the agency have written policies and procedures that assure patient confidentiality (In accordance with Maryland Annotated Code) with regard to transmission, maintenance and security of medical information?

   ☐ Yes ☐ No

5. Does the agency have written policies and procedures regarding breaking confidentiality if the provider(s) feels that the child is in danger or in some way threatens someone else?

   ☐ Yes ☐ No

6. Does the agency have written policies and procedures regarding the provision of culturally appropriate care to their patients?

   ☐ Yes ☐ No

C. Access, Care and Provider Continuity

7. Does the agency have mechanisms in place for urgent care evaluation and/or triage?

   ☐ Yes ☐ No

   ▸ If Yes, describe these mechanisms.

8. Does the agency have mechanisms in place to facilitate access to the following services If needed:

   ☐ Yes ☐ No Therapeutic day care
   ☐ Yes ☐ No Therapeutic foster homes
   ☐ Yes ☐ No Day hospital
   ☐ Yes ☐ No Residential treatment facilities
   ☐ Yes ☐ No Inpatient psychiatric unit

   ▸ If Yes, describe these mechanisms.

9. Does the agency have mechanisms in place to ensure continuity of mental health/psychiatric care to their patients when the clients are in the following care settings:

☐ Yes	☐ No	Therapeutic day care
☐ Yes	☐ No	Level V school programs
☐ Yes	☐ No	Residential treatment facilities
☐ Yes	☐ No	Day hospitals
☐ Yes	☐ No	Substance abuse programs
☐ Yes	☐ No	Inpatient psychiatric units
☐ Yes	☐ No	Inpatient medical units
☐ Yes	☐ No	Rehabilitation hospitals
☐ Yes	☐ No	Hospice programs

▸ If Yes, describe these mechanisms.

10. Has the agency developed and maintained linkages with substance abuse treatment providers to maintain care continuity for patients with dual diagnoses of substance use disorders and other mental health disorders?

☐ Yes ☐ No

▸ If Yes, describe these mechanisms.

D. Quality Improvement

11. Does the agency have an on-going quality improvement/quality assurance program for mental health services that identifies areas for improvement and subsequent actions taken?

☐ Yes ☐ No

12. Are utilization review decisions based on best practice and consistent with established treatment guidelines?

☐ Yes ☐ No

13. Does the agency have a process for clients to evaluate the agency, staff and services?

☐ Yes ☐ No

▸ If Yes, describe this process.

OPERATIONAL & PERFORMANCE STANDARDS FOR MENTAL HEALTH SERVICES TO CHILDREN AND ADOLESCENTS

ratified: October, 1997; reviewed September 1999.

STANDARD OF CARE 1.0

Mental health and Psychiatric care for persons with HIV disease should reflect competence and experience in evaluation, formulation, and diagnosis as well an in evidence-based therapeutics, using contemporary practice guidelines where available.

The following components of evaluation and treatment should be standard practice with all patients/clients and be reflected in medical record documentation. These standards are specifically for use with children and adolescents, ages birth through 18.

1.1 AN INITIAL EVALUATION SHOULD BE CONDUCTED PRIOR TO THE BEGINNING OF ANY TREATMENT. THIS EVALUATION MUST BE CONDUCTED BY A LICENSED MENTAL HEALTH PROFESSIONAL, WORKING AS PART OF AN INTERDISCIPLINARY TEAM. THIS TEAM SHOULD CONSIST OF, AT A MINIMUM, A PEDIATRICIAN AND/OR CHILD PSYCHIATRIST, LICENSED PSYCHOLOGIST, NURSE, AND/OR SOCIAL WORKER. THE EVALUATION MUST CONSIST OF THE FOLLOWING:

a. History: chief complaint, prenatal and neonatal history, developmental history including milestones, social/emo tional factors of infancy and childhood, family history, medical history, premorbid functioning, review of systems, current and recent medication, school history, sibling and peer relations, placement history (e.g., foster care, kinship care), and review of any prior treatment and evaluations.
b. Developmentally appropriate mental status exam.
c. Cognitive, emotional, and/or behavioral assessment should be conducted by a psychologist with appropriate training and experience, (either Licensed psychologist or a supervised psychology associate). These evaluations may include formal, individually-administered, standardized developmental/intellectual/achievement/personality/ and/or neuropsychological tests; parent and/or patient self-report behavioral and/or emotional measures; or a screening assessment in one or more of the above areas.
d. Laboratory assessment as clinically indicated.
e. Multi-axial differential diagnosis leading to final diagnostic formulation assessment.
f. Treatment plan with specific measurable goals through the use of appropriate outcome
g. Practice guidelines for specific conditions/situations/disorders consistent with the practice of the evaluators (American Psychological Association/American Psychiatric Association). This should include written communication with the patient's primary care provider/referral source at the time of initial evaluation and at points of regular review (three month intervals), and at time of discharge from mental health services.

1.2 FOLLOW-UP VISITS TO PROVIDE OR MONITOR TREATMENTS AND TO ASSESS PROGRESS TOWARD MEETING GOALS

One significant issue in the treatment of HIV affected children is the issue of disclosure. Many HIV-infected children have not been told about their sero-status. Furthermore, other individuals involved in their care may not know about their status (e.g., family members, school). Another major issue in the treatment of children involves the actual referral for treatment. Many children who enter treatment are referred by family, school, or health care providers. Children, unlike adults. do not seek services and are frequently unaware of the reason for referral. Finally, age, developmental level, and presenting complaint are major considerations In the selection of treatment modality, as well as the scope and intensity of services provided.

a. Visit frequency averaging every week to two weeks for patients with active symptoms working toward a short term goal. For those whose symptoms are in remission but remain on psychotherapeutic medicines visits averaging every three months are necessary.

b. Therapeutic services for children vary significantly with the age, developmental level, and disclosure status of the child. Specific types of psychotherapy for children may include: Individual Play Therapy, Therapeutic Play Groups, (e.g., play group for children 4 - 8 years of age), Parent/Child therapy (e.g., behavior management/parenting skills/communication enhancement-parent/child interaction therapy), Parent/Caregiver therapy groups, social skills groups, Family Therapy. School based consultation around mental health issues, and grief/bereavement therapy.

c. The Prescription and monitoring of appropriate medication as indicated by the clinical situation, evidence-based practice guideline recommendations, and linked to specific treatment goals. Prescription and monitoring of stimulant medications (e.g., Ritalin) and central antihypertensive medications (used to treat ADHD e.g., Clonidine) can be provided by a pediatrician, while psychotropic medications must be provided by a child psychiatrist.

d. For those children or adolescents on medication, the Pediatrician, Child Psychiatrist or Nurse will provide medication administration training and side effect monitoring to the parent/caregiver of the child, and developmentally appropriate medication information to the child.

e. Monitoring of the patient's progress toward treatment plan goals through the use of appropriate outcome assessment (e.g., parent/caregiver and/or child self-report, school report).

f. Reassessment of each patient treatment plan and progress by the interdisciplinary team every three months.

STANDARD OF CARE 2.0

HIV mental health providers must show compliance with the following standards regarding: (a) licensure Qualifications of care providers; (b) confidentiality and regard for patient rights: (c) access, cultural appropriateness, and continuity of care; and (d) quality of care improvement efforts.

2.1 LICENSING, KNOWLEDGE, SKILLS, AND EXPERIENCE

a. All staff delivering mental health services will posses current organizational and professional licensure.

b. Non-licensed staff or trainees delivering mental health services will receive professional supervision of the care they are providing to individual patients/clients, by a licensed mental health provider.
c. All staff delivering mental health services will either have specific experience in caring for HIV-infected patients or receive appropriate training.

2.2 PATIENT RIGHTS AND CONFIDENTIALITY

a. The provider organization will provide assurance and a method of protection of patient rights in the process of care provision.
b. The provider organization will provide assurances and a method of protection of patient confidentiality, with regard to medical information transmission, maintenance and security.
c. In working with children, confidentiality must be broken, by State of Maryland law, if the provider feels that the child is in danger or in some way threatens someone else.
d. The provider organization will provide assurances regarding the provision of culturally appropriate care to their patients.

2.2 ACCESS, CARE AND PROVIDER CONTINUITY

a. The provider organization will provide clinical services in a timely fashion to all patients.
b. The provider organization will provide mechanisms for urgent care evaluation or triage.
c. The provider organization will provide mechanisms to make available to it's patients/clients access, if clinically indicated, to the full range of mental health treatment settings including therapeutic day care, therapeutic foster homes, day hospital, residential treatment facilities, and inpatient psychiatric unit.
d. The provider organization will provide mechanisms provide mechanisms for continuity of mental health/psychiatric care to their patients is all settings in which they may receive care, including but not limited to therapeutic day care, Level V school programs, residential treatment facilities, day hospitals, substance abuse programs, inpatient psychiatric units, inpatient medical units, rehabilitation hospitals, and hospice programs.
e. The provider organization will develop and maintain linkages with substance abuse treatment providers, such as to maintain continuity for patients with dual diagnoses of substance use disorders and other mental disorders.

2.4 QUALITY IMPROVEMENT

a. The provider organization will provide for methods to monitor for areas in need of improvement.
B. The provider's organization will provide methods for the development of corrective action and the assessment of the effect of such actions, regarding areas in need of improvement.